STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953272	11/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lakewood Retirement Center	1220 Jimmy Ann Drive Daytona Beach, FL 32117	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0010-Admissions - Continued Residency-11/07/2014
0052-Medication - Assistance With Self-Admin-11/07/2014
Z815-Background Screening; Prohibited Offenses-11/07/2014

Revisit New Tags:
0056-Medication - Labeling And Orders-58a-5.0185(7) Fac
0077-Staffing Standards - Administrators-58a-5.019(1) Fac

Specific Tag Findings:

0000-Initial Comments
An unannounced re-visit survey was conducted on 11/7/14 at Lakewood Retirement Center in Daytona Beach, Florida. Deficiencies were identified at the time of the visit.

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review, observation and staff interviews the facility failed to ensure all medications ordered by physicians were obtained from the pharmacy in a timely manner and documented on the Medication Observation Records at the time the order was received for 2 of 3 sampled residents. (Residents # 1 and 2).

The findings include:

1. Record review for Resident # 1 revealed female admitted . Her diagnoses included: and . The most recent Health Assessment (1823) was completed on . Review of the medication list signed by the physician included a new order for 300mg (treatment of once daily at bedtime. Review of the Medication Observation Record (MOR) revealed the was not listed on the or 2014 MOR 's. The 2014 MOR revealed was listed on the MOR, however was not documented as given.

An interview was conducted with the Medication Technician (MT) on 11/7/14 at 12:05pm. When asked if Resident # 1 was ordered 300mg at bedtime she stated she did not know because she did not give medications on the evening shift. She reviewed the 2014 MOR and stated there was an order for the medication but it had not been signed as given this month. When asked if the medication was available in the medication cart she stated she would look. She produced a full card of medication with no pills removed. She also stated that she gives medications every day and did not recall the medication being in the drawer until today. When asked what date the medication was filled by the pharmacy, the date on the card indicated it was filled on . She then stated she would call the pharmacy and check what date it had been filled and sent to the facility.

An interview was conducted with the Pharmacy Technician on 11/7/14 at 4:00pm. She confirmed that the order was entered into the system on and not sent until . She stated she was waiting to hear from the facility or physician for confirmation of the order because the resident had only received the medication one time previously. When asked if the physician had confirmed the order, she stated " yes ".

An interview was conducted with the Registered Nurse (RN) consultant on at 12:45pm. When asked who

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reviewed the MOR's and physician orders, she stated the facility had an RN who had been assisting the facility with inservicing and developing a plan of correction, however she resigned and I was recently hired to consult. She was asked to review the MOR for Res #1 and asked if the resident was receiving , she stated it was on the MOR but not documented as given. She verified the medication was in the cart but no pills had been removed.

She was asked if the physician had been notified that the resident had not received the medication since it was ordered on , she stated "no" but would call today.

An interview was conducted with the Administrator on at 1:15pm. When asked who was responsible for reviewing the MOR ' s and physician orders for accuracy, She stated she hired an RN consultant who was responsible for reviewing all medication records and checking them with the physician orders to ensure the records were up to date. When asked how new medication orders were transcribed to the MOR ' s, she stated that whoever was on duty would record the medication on the MOR and fax the order to the pharmacy. When asked if she was aware that Resident #1 had a new order for Neurotin ordered by the physician on and had not yet received. She stated she was not aware until today. The Administrator stated as part of the directed plan of correction all residents were assessed and new Health Assessments (1823) were obtained. She was so busy trying to get them all done that she saved them and sent them all at once to the pharmacy to update the records. The 1823 ' s were all sent on and that is when the new order was found by the pharmacy. The medication however, was not sent to the facility until . When asked if that was consistent with the new plan of correction the facility had put into place, she stated she thought it was, since she had hired an RN to oversee the process.

The physician ' s office was called on at 4:15pm. Surveyor requested to speak with the physician. He was out of the office making rounds, however was on call and his office could give him the message. The nurse was told of the situation regarding Resident #1 and that ordered by the physician on had not yet been started at the facility. The physician called at 5pm on and left message on voicemail stating he was not aware of the resident not receiving the medication and would call the facility and follow-up, as he wanted the resident to have the medication.

2. Record review for Resident #2 revealed I male with diagnosis including: and chronic kidney . Review of the 2014, MOR revealed an order for 12.5mg . The MOR indicated none had been documented as given in . Review of the physician order revealed the medication had been ordered on . Observation of the medication revealed the fill date was but was not delivered to the facility . An interview was conducted with the MT on at 12:05pm. She was asked if the resident had been receiving . She reviewed the MOR and stated " no ", the medication did not arrive until last night. The MOR did not contain the order for and no indication the medication was given.

An interview was conducted with the RN consultant on at 12:45pm. When asked what date was ordered for Res #2, she stated she would need to review the orders. She stated the physician order was dated but not sent by the pharmacy until . When asked why the delay from the pharmacy, she stated she would need to call the pharmacy. After speaking with the pharmacy, she reported that

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the pharmacy received the order on , however, because they were backed up with orders they did not get it out until .

An interview was conducted with the Administrator on at 3:50pm. When asked if she was aware the pharmacy was not delivering resident medications timely (10 days) she stated she did not. She was asked what the expectation is when medications are ordered, she stated usually the same day or next day if the order comes in late in the day. When asked who was responsible for ensuring all medications are available, she stated all MT ' s assisting with medications. When asked what the procedure is, if a medication is not available, she stated the MT is to report to the RN and if she was not at the facility, they notify me and I call the pharmacy. When asked if a 10 day delay in medication delivery was acceptable, she stated " no "

A review of the Directed Plan of Correction, hand delivered by the agency on revealed that the facility was directed to complete the following: "The facility must employ, by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse to address auditing medication observation records in comparison with physician orders. The facility must employ the pharmacist or Registered Nurse, no later than . The consultant must develop a written plan of action for addressing the deficient medication practices identified in the statement of deficiencies. The consultant must conduct monthly audits of the medication observation records in comparison to current physician orders for each resident for a minimum of 3 months. The results of these audits must be sent to the Field Office for review. " The plan developed by the consultant dated read "Contracted RN will review MORS every month first day of the month along with the member's doctor's orders to ensure all orders are up to date and transferred correctly onto the MOR. Audit tool has been developed and will be sent to AHCA every month until compliance is obtained". The completion date was listed as "every month starting As of , the field office had not received any documentation from the facility regarding audits of the MOR's on a monthly basis.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on record review, observation and staff interviews the administrator failed to ensure adequate supervision of the staff assisting residents with medications and failed to monitor implementation of the Directed Plan of Correction potentially affecting all residents in the facility.

The findings include:

1. Record review for Resident # 1 revealed female admitted . Her diagnoses included: , and . The most recent Health Assessment (1823) was completed on . Review of the medication list signed by the physician included a new order for 300mg (treatment of once daily at bedtime. Review of the Medication Observation Record (MOR) revealed the was not listed on the or 2014 MOR ' s. The 2014 MOR revealed was listed on the MOR, however was not documented as given.

An interview was conducted with the Medication Technician (MT) on at 12:05pm. When asked if Resident # 1 was ordered 300mg at bedtime she stated she did not know because she did not give medications on the evening shift. She reviewed the 2014 MOR and stated there was an order for the medication but

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it had not been signed as given this month. When asked if the medication was available in the medication cart she stated she would look. She produced a full card of medication with no pills removed. She also stated that she gives medications every day and did not recall the medication being in the drawer until today. When asked what date the medication was filled by the pharmacy, the date on the card indicated it was filled on . . . . She then stated she would call the pharmacy and check what date it had been filled and sent to the facility.

An interview was conducted with the Pharmacy Technician . . on . . . . at 4:00pm. She confirmed that the order was entered into the system on . . and not sent until . . . . . She stated she was waiting to hear from the facility or physician for confirmation of the order because the resident had only received the medication one time previously. When asked if the physician had confirmed the order, she stated " yes " .

An interview was conducted with the Registered Nurse (RN) consultant on . . . . . at 12:45pm. When asked who reviewed the MOR's and physician orders, she stated the facility had an RN who had been assisting the facility with inservicing and developing a plan of correction, however she resigned and I was recently hired to consult. She was asked to review the MOR for Res #1 and asked if the resident was receiving . . . she stated it was on the MOR but not documented as given. She verified the medication was in the cart but no pills had been removed.

She was asked if the physician had been notified that the resident had not received the medication since it was ordered on . she stated "no" but would call today.

An interview was conducted with the Administrator on . . . . . at 1:15pm. When asked who was responsible for reviewing the MOR ' s and physician orders for accuracy, She stated she hired an RN consultant who was responsible for reviewing all medication records and checking them with the physician orders to ensure the records were up to date. When asked how new medication orders were transcribed to the MOR ' s, she stated that whoever was on duty would record the medication on the MOR and fax the order to the pharmacy. When asked if she was aware that Resident #1 had a new order for Neurotin ordered by the physician on . . . and had not yet received. She stated she was not aware until today. The Administrator stated as part of the directed plan of correction all residents were assessed and new Health Assessments (1823) were obtained. She was so busy trying to get them all done that she saved them and sent them all at once to the pharmacy to update the records. The 1823 ' s were all sent on . . . . . and that is when the new order was found by the pharmacy. The medication however, was not sent to the facility until 11. . . When asked if that was consistent with the new plan of correction the facility had put into place, she stated she thought it was, since she had hired an RN to oversee the process.

The physician ' s office was called on . . . at 4:15pm. Surveyor requested to speak with the physician. He was out of the office making rounds, however was on call and his office could give him the message. The nurse was told of the situation regarding Resident #1 and that . . . . . ordered by the physician on . . . . had not yet been started at the facility. The physician called at 5pm on . . . . . and left message on voicemail stating he was not aware of the resident not receiving the medication and would call the facility and follow-up, as he wanted the resident to have the medication.

2. Record review for Resident #2 revealed . . male with diagnosis including: . . . and

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chronic kidney . . . . . Review of the 2014, MOR revealed an order for . 12.5mg . The MOR indicated none had been documented as given in . . . . . Review of the physician order revealed the medication had been ordered on . . . . . Observation of the medication revealed the fill date was . . . . . but was not delivered to the facility . . . . An interview was conducted with the MT on at 12:05pm. She was asked if the resident had been receiving . She reviewed the MOR and stated " no ", the medication did not arrive until last night. The . . . MOR did not contain the order for . and no indication the medication was given.

An interview was conducted with the RN consultant on . . . . . at 12:45pm. When asked what date was . ordered for Res #2, she stated she would need to review the orders. She stated the physician order was dated . . . . . but not sent by the pharmacy until . . . . . When asked why the delay from the pharmacy, she stated she would need to call the pharmacy. After speaking with the pharmacy, she reported that the pharmacy received the order on , however, because they were backed up with orders they did not get it out until . . . . . .

An interview was conducted with the Administrator on . . . . at 3:50pm. When asked if she was aware the pharmacy was not delivering resident medications timely (10 days) she stated she did not. She was asked what the expectation is when medications are ordered, she stated usually the same day or next day if the order comes in late in the day. When asked who was responsible for ensuring all medications are available, she stated all MT ' s assisting with medications. When asked what the procedure is, if a medication is not available, she stated the MT is to report to the RN and if she was not at the facility, they notify me and I call the pharmacy. When asked if a 10 day delay in medication delivery was acceptable, she stated " no " .

A review of the Directed Plan of Correction, hand delivered by the agency on . . . . . revealed that the facility was directed to complete the following: "The facility must employ, by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse to address auditing medication observation records in comparison with physician orders. The facility must employ the pharmacist or Registered Nurse, no later than . . . . . The consultant must develop a written plan of action for addressing the deficient medication practices identified in the statement of deficiencies. The consultant must conduct monthly audits of the medication observation records in comparison to current physician orders for each resident for a minimum of 3 months. The results of these audits must be sent to the Field Office for review. " The plan developed by the consultant dated . . . . . read "Contracted RN will review MORS every month first day of the month along with the member's doctor's orders to ensure all orders are up to date and transferred correctly onto the MOR. Audit tool has been developed and will be sent to AHCA every month until compliance is obtained". The completion date was listed as "every month starting . . As of , the field office had not received any documentation from the facility regarding audits of the MOR's on a monthly basis.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Lakewood Retirement Center
1220 Jimmy Ann Drive
Daytona Beach, FL 32117

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 7, 2014 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, and new deficiencies that were identified on the day of the visit.

All deficiencies shall be corrected no later than , 2014.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at (904) 798-4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KJ/JM/sm
Enclosure

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